What we’ll cover

• Details of the new California law
• How often do patients request aid in dying, and why?
• How might palliative care teams be involved?
California End of Life Option Act

History

• Signed into law by Gov. Jerry Brown on October 5\textsuperscript{th}, 2015

• Goes into effect June 9\textsuperscript{th}, 2016
CA End of Life Option Act

Allows terminally ill patients to request a drug that will end the patient’s life

- Must be >18 and CA resident
- Must have a terminal disease with a prognosis of <6 months
- Must have capacity to make decision
- Must not have impaired judgment due to a mental disorder
- Have the ability, mentally and physically, to take the drug independently
- Cannot be requested in advance directive, nor by surrogates
CA End of Life Option Act

Process:
• Attending physician determines prognosis and capacity
• Patient must make two oral requests at least 15 days apart directly to the same physician, as well as one written request
• Written request on a special form that is witnessed and signed by patient
• Must be done without anyone else present (except interpreter) to insure voluntariness
CA End of Life Option Act

Process:
• The patient must then see a second physician (consulting physician) who can confirm diagnosis, prognosis, and capacity
• If either physician thinks the patient may have a mental disorder [sic], they must also see a mental health specialist to ensure unimpaired judgment
CA End of Life Option Act

Process:
• The pt and physician must discuss:
  – How the drug will affect the patient, and that death might not come immediately
  – Realistic alternatives to PAD including hospice, palliative care and pain control
  – Whether the patient wants to withdraw the request
  – Whether the patient will notify next of kin, whether someone else will be present, or participate in hospice (none of these required)
CA End of Life Option Act

Process:

• Physician writes prescription
• Final attestation: Patient must sign a form 48 hours before taking drug saying they took the drug voluntarily (new CA addition)
CA End of Life Option Act

• Any provider can decline to participate for reasons of “conscience, morality, or ethics”

• Health care institutions may prohibit provider participation while on premises or within scope contract/employment
  – May not prohibit physicians or others from providing diagnosis/prognosis, counseling/discussing options, referring to physician who will provide assistance under the Act
Turn to your neighbor

• Have you had patients ask you about hastening death? How have you responded?
How often do patients think about aid in dying?

60% of patients with a terminal illness supported PAS/euthanasia in theory

10% seriously considered it for themselves, *not stable over time*

1.6% asked their physicians

Why do patients ask for aid in dying?

- Oregon 2015 data

<table>
<thead>
<tr>
<th>End of life concerns</th>
<th>(N=132)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less able to engage in activities making life enjoyable</td>
<td>127 (96.2)</td>
</tr>
<tr>
<td>Losing autonomy</td>
<td>121 (92.4)</td>
</tr>
<tr>
<td>Loss of dignity</td>
<td>98 (75.4)</td>
</tr>
<tr>
<td>Losing control of bodily functions</td>
<td>46 (35.7)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers</td>
<td>63 (48.1)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it</td>
<td>37 (28.7)</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
<td>3 (2.3)</td>
</tr>
</tbody>
</table>

Turn to your neighbor

• What do you think the role of palliative care providers should be in responding to patients who request the End of Life Option Act?
  – On an individual level
  – At your organization
Why should the palliative care community be involved?

What patient says
I’m thinking about aid in dying

What patient is thinking
Will I have pain?
Will I be a burden?
I’m afraid
I’m sad
Please talk to me
Why should the palliative care community be involved?

• This is our strength!

• Palliative care providers are uniquely poised to explore and respond to patient needs that *underlie* requests, does not mean they need to prescribe.¹

• Most patients who request aid in dying do not obtain prescription or use it; substantive interventions by physicians led many patients to change their minds.²

Why should the palliative care community be involved?

• Lessons from OR and WA: “silver lining” of Death with Dignity Acts was improved end of life care
• Practitioners and institutions will need to respond regardless of whether they intend to prescribe
For California providers...

• The law leaves many gaps to fill
• Does your hospital/facility have a policy or workflow for responding to requests under EOLOA? What is it?
Unanswered questions

• What education is necessary to prepare all providers (physicians, nurses, social workers, chaplains, administrative staff) to respond to requests, whether the facility opts to participate or not?
• How to make patients who request aid in dying drugs aware of their options for end of life care?
• **Will the clinic/facility allow physicians to prescribe medications under the EOLOA?**
• If the overall system chooses to participate, how to allow conscientious objection for individual providers and personnel to ensure continuity of care and access for patients?
• Will there be a credentialing process for physicians who choose to participate?
• Will the clinic/facility require any additional steps beyond the recommendations of the law (e.g. psychosocial evaluation, palliative care consult, advance care planning, hospice referral?)
• What new resources need to be put into place to handle patient requests and comply with law requirements and any additional institutional requirements (e.g. patient navigators, educational materials for patients, checklists for staff, phone lines)?
• Whether to formalize a process for one-on-one conversations with patients as required by law, and how to deal with patients that prefer family decision-making?
• Who will be responsible for the collection and submission of forms, including the final attestation form?
• How to deal with conflict resolution and professional non-compliance?
• How to support providers and mitigate moral distress?
• If the system chooses not to participate, will it permit physicians to refer patients? How is a referral defined?
• How to make all employees aware of the institutional policy?
• How to instruct patients and families to safely dispose of unused medications?
Resources

• EOLARC website (Password: ethics)
  http://www.eoloptionacttaskforce.org/resources.html
• UC Hastings EOL Options Act Fact Sheet:
• AAHPM Position Statement:
  http://aahpm.org/positions/padbrief
• Coalition for Compassionate Care
  http://coalitionccc.org/tools-resources/end-of-life-option-act/
• CAPC Fast Facts
  http://www.mypcnow.org/#!blank/pbq3l
  http://www.mypcnow.org/#!blank/q24sj
• Oregon Death With Dignity Act Guidebook
Questions?
Thank you

• PCQN
• Barbara Koenig, Lindsay Forbes, Ben Scribner
The Ingestion Process
(Orentlicher, 2015 JPM)

- Antiemetic (zofran or metaclopramide) administered
- 45-60 mins later, patient ingests barbiturate*
  - The powdered barbiturate is mixed with half a cup of water into a slurry
  - It should be ingested quickly within 30-120 seconds, otherwise pt may fall asleep before ingesting the full dose
  - May drink juice or liquids but not fatty foods
- In OR/WA, to maintain confidentiality, death certificate usually includes “respiratory failure” or the underlying terminal disease as immediate cause of death

*Prescribing trends have changed over time; secobarbital and pentobarbital were most common. A new, cheaper alternative (phenobarbital, chloral hydrate, morphine sulfate) is gaining popularity in Oregon due to cost.